CENTRE FOR MENTAL HEALTH

NHS RACE & HEALTH OBSERVATORY

Coffee Afrik CIC

# TRAUMA-INFORMED CARE AND RACIALISED COMMUNITIES

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Centre for Mental Health thanks all the research participants who attended focus groups and one-to-one interviews and spoke openly about trauma and trauma-informed care in racialised communities.

Thanks also to Sam Rodger of the NHS Race and Health Observatory for his support throughout.

# FOREWORD

## BY HABIB NAQVI AND ANDY BELL

Over the past few years, our collective understanding of trauma has grown more sophisticated. It's become common in healthcare spaces – and especially mental health environments – to describe the care provided as trauma-informed. But, as this research shows, this understanding is patchy and inconsistent. Nowhere is this more apparent than at the intersection between trauma and racism.

Racially marginalised communities in this country contend with intersecting forms of trauma, not least the intergenerational burden of systemic and interpersonal racism. There are testimonies within this report that spell out the everyday experiences of race inequity that serve to erode a person's resilience. These experiences happen everywhere, in the streets, at school, the workplace, in interactions with the police and, crucially for us, with mental health services.

The report shows that, at its worst, our healthcare service can reproduce negative experiences - traumas accumulated over lifetimes or generations are compounded by feelings of dismissal or disbelief. Service users are written off or ignored based on how they look, their accent, or assumptions about their cultures.

However, the report here also shows that, at their best, mental health services can be coproduced and codesigned with communities to genuinely embed an understanding of race and racism; the intersecting ways in which racialised communities experience trauma and treatment, and the endlessly unique journeys we take before we enter formal healthcare pathways. Coffee Afrik, with whom we collaborated on this report, is a prime example of what it means to put communities and the value of healing at the heart of mental health care.

This report makes a compelling case for a new kind of trauma-informed care, one that appreciates not only the ways in which structural racism causes trauma but also considers the role our healthcare system can play in compounding or mitigating that trauma. This new form of trauma-informed care will recognise that a one-size-fits-all model cannot work and that when a person has used a service, they return to the social, political and cultural context in which they live, and the systemic injustices that entails.

This country is at a crossroads when it comes to race equity. The past few years have seen a return of racial violence both to our streets and to mainstream political rhetoric. Anti-migrant and racist sentiment are growing in a way that we hoped was long in the past. In our healthcare services, however, there are signs that more progressive practice is starting to take root.

The reform of the Mental Health Act was born at least partly of a desire to correct historic racial inequities; the Patient and Carer Race Equality Framework and other resources are seeking to embed anti-racism and community voice in the delivery of mental health services; and the advent of the Neighbourhood Health Service, if properly implemented, could bring care closer to minoritised communities, both geographically and in their design.

One of the main things that stands out in this report is the power of listening. In developing this work, we listened to the very often traumatic experiences of marginalised people, but we also learnt that listening is among the most powerful interventions in the deployment of genuinely anti-racist trauma-informed care. Only in truly equitable and meaningful partnership can we make this new kind of care possible and create spaces that enable service users and staff alike to heal and to thrive.

**Andy Bell is CEO of Centre for Mental Health, and Habib Naqvi is CEO of the NHS Race and Health Observatory.**

# EXECUTIVE SUMMARY

## BACKGROUND

Racialised communities in the UK face disproportionately high levels of trauma linked to racism, discrimination, socio-economic inequality, migration experiences, and structural injustice. Trauma is often cumulative and intergenerational, shaped by historical forces such as slavery, colonialism and displacement, and reinforced by contemporary inequities in education, health care, policing, housing and employment. The Windrush scandal, persistent stereotypes in clinical settings, overdiagnosis of psychosis among Black communities, and discriminatory school experiences illustrate how trauma is repeatedly reproduced through public institutions.

Although interest in trauma-informed care is growing within the NHS, current provision remains fragmented and inconsistent. Trauma-informed approaches are rarely adapted to the realities of racial trauma, meaning that people from racialised communities often do not experience care that acknowledges the cultural, historical and structural conditions shaping their lives. Many of these people also face additional barriers to care, including mistrust, language challenges, stigma, and prior negative experiences in services where they felt dismissed, misunderstood or re-traumatised.

To address these gaps, the NHS Race and Health Observatory commissioned this research, delivered by Centre for Mental Health and Coffee Afrik CIC. The project explores the nature of trauma for racialised communities, the experiences people have with public services, and the changes required to deliver trauma-informed, culturally grounded and anti-racist care.

## METHODS

The study drew on a wide range of qualitative methods:

- A **comprehensive literature review** established the national and international evidence base on trauma, racial trauma, trauma-informed care, and structural inequality
- The **formation of a community reference group** of Black young men, who helped shape the research questions and ensured cultural relevance throughout the project
- An **online survey** gathered the views of 22 professionals working across mental health, education, criminal justice, the voluntary sector and community settings. Respondents represented varied ethnic backgrounds and levels of experience, and their insight provided a view of how trauma-informed care is understood and delivered within services

To capture lived experience, **51 service users from across the UK participated in interviews and focus groups**. They included people of African, Caribbean, Asian, Middle Eastern, Central American and mixed-heritage backgrounds, as well as refugees, asylum seekers and migrants. Participants varied in age, gender, faith, disability, immigration status and sexual orientation. Interviews lasted up to ninety minutes and were conducted in culturally sensitive ways, including the use of interpreters and trauma-informed practices.

This mixed approach provided a rich and nuanced picture of how trauma is experienced and how services respond.

## KEY FINDINGS

### Trauma is widespread, interconnected, and rooted in racism

Participants described the daily impact of racism in public spaces, workplaces, schools and housing. Many shared experiences of verbal abuse, stereotyping and discriminatory treatment. These interpersonal experiences were reinforced by structural injustices that limited access to safe housing, quality healthcare, stable employment and fair treatment from police. Several described early experiences of racism in school as formative and long-lasting, affecting self-worth and educational attainment.

People also spoke about intergenerational trauma linked to colonial histories, enslavement, war, political oppression and forced migration. Refugees and asylum seekers described perilous journeys, loss of family networks, and the emotional toll of uncertain immigration processes. Trauma was layered: even after fleeing danger, participants often encountered new forms of discrimination, hostility and insecurity in the UK.

### Public services often reproduce trauma rather than alleviate it

Experiences with healthcare, policing, housing and social care frequently compounded people's distress. Some participants felt dismissed by clinicians, particularly when reporting pain, mental distress or symptoms that did not align with Eurocentric understandings of ill health. Women described feeling blamed or disbelieved, especially when presenting with trauma linked to violence.

Several participants recounted negative encounters with police, including being stopped or searched without cause, or being treated as perpetrators when they were seeking help. Others described discriminatory treatment in housing services, leaving them in unsafe or unsuitable accommodation. These experiences deepened mistrust of institutions and discouraged people from seeking help.

### Trauma-informed care is inconsistently applied and rarely anti-racist

Professionals who responded to the survey understood trauma and its effects but varied significantly in how they interpreted trauma-informed care. Many said their organisations lacked consistent policies, training or leadership support. While some believed their services were trauma-informed, nearly half were uncertain or felt that culturally competent, anti-racist practice was not embedded.

### Community-led care is vital but underfunded

Participants emphasised the stabilising role of community groups, cultural practices, faith networks and grassroots organisations. These services often provided the emotional safety, cultural understanding and practical support that statutory services lacked, yet they operated with insecure funding and limited recognition.

## CONCLUSIONS

Trauma among racialised communities in the UK is shaped by overlapping histories of racism, migration, discrimination and exclusion. Effective trauma-informed care must therefore be culturally responsive, anti-racist and grounded in an understanding of structural inequality. A generic, one-size-fits-all model cannot meet the needs of people whose trauma is embedded in their social and political context.

This study highlights the importance of approaching trauma through a human-rights lens, recognising that trauma is not merely an individual psychological event but a consequence of systemic injustices. It also underscores the need for cultural humility, which requires practitioners and organisations to examine their own biases and assumptions rather than expecting service users to adapt to dominant norms.

We must recognise the resilience and agency within racialised communities and champion genuine partnership with communities, ensuring they shape the design, delivery and evaluation of services. Trauma-informed work must address trauma across the whole life course and across the whole system, rather than focusing narrowly on individual treatment.

Sustained leadership, clear accountability and adequate resources are required to embed this work across health, education, policing, housing and other public services.

## RECOMMENDATIONS

1. NHS England/DHSC must continue to implement, in full, the Patient and Carer Race Equality Framework (PCREF) across all mental health services for all ages, with clear accountability structures for the completion of this important transformation programme. This should include board-level accountability and clear public milestones for providers.
2. The Government must take assertive and concerted action to tackle racism and racial inequality. The Government's pledge to create a new Race Equality Act is an important start, but it requires cross-government action to address all dimensions of injustice and inequity. The eventual Act should have enforceable duties, mandatory impact assessments, and measurable outcome targets across health, education, housing and justice.
3. Every integrated care board (ICB) must ensure that it is commissioning mental health support which effectively meets the needs of racialised and marginalised communities. This should be done in line with the Strategic Commissioning Framework but must include using data about need and service provision to identify gaps or quality concerns in existing provision. Plans should be codesigned and coproduced with people and organisations from racialised communities.
4. All NHS-funded mental health service providers must embed trauma-informed and anti-racist practice as core organisational standards across all their services, with a deep awareness of intersections with gender, sexuality, neurodiversity and other dimensions of inequality and inequity. This should include mandatory training, outine monitoring of disparities in access and outcomes, and transparent reporting on progress, with accountability at executive and Board level.

5. The Care Quality Commission must explicitly assess implementation of PCREF and trauma-informed practice within inspection frameworks, publish ratings on equity performance, and require time-bound improvement plans where standards are not met.
6. NHS, local authority, charitable and research funders should provide secure and sustainable funding for community-led organisations, both as providers of support and as advocates for their communities. They should adapt commissioning and grant criteria to recognise community-based evidence, reduce administrative barriers, and promote equitable access to funding.
7. Training providers and professional bodies across all mental health professions must make trauma-informed and anti-racist practice mandatory within pre-registration training and CPD requirements, with assessed competencies and revalidation standards aligned to these principles.
8. The Department for Education should require all schools and colleges to include education about racism and colonialism and require teacher training to include learning about racism and microaggressions in school and college settings.

# BACKGROUND

Trauma-informed care in the UK is not currently centralised, but it is being introduced into the long-term plans of the NHS. In a 2022 qualitative study, Emsley *et al*. found that healthcare professionals were concerned about this lack of standardisation, and suggested the adoption of a nationwide policy together with increased government funding. Few studies have explored the effectiveness of trauma-informed care for the wellbeing and mental health of racialised communities, and this is where the need for our research comes in.

In 2022, the NHS Race and Health Observatory produced a report on ethnic inequalities which showed that people from racialised communities are less likely to receive adequate support from mental health services. People from racialised communities have negative experiences with mental healthcare professionals, and in some cases do not have access to mental health care services at all. An earlier qualitative study (Memon *et al*., 2016) found that fear of discrimination from mental health care professionals, stigma, racism and communication barriers are factors that discourage racialised community members from seeking support.

Culture has also been found to play a key role in trauma responses. Research has shown that there is an increased risk of post-traumatic stress disorder (PTSD) in a wide range of cultures, often as a consequence of having experienced traumatic events such as genocide or natural disasters (SAMHSA, 2014).

People from racialised communities, specifically Black communities, have experienced historical trauma because of racism, slavery and segregation (Conner, 2020). Black Caribbean people from the Windrush generation have also faced trauma and discrimination during and since their arrival in Britain in the late 1940s. The events of 2018 - when Black Caribbean people who had lived legally in Britain for more than half a century were wrongly detained, denied legal rights, and in some cases unjustly deported - caused material loss and psychological damage. The loss and damage was not only to the victims themselves but also to their children, grandchildren, other relatives and friends whose confidence that they are safe in this country has been undermined as a consequence (Hines, 2018; Joint Council for The Welfare of Immigrants, 2020). Research has found that historical trauma can be passed down to future generations and can also have a negative effect on the genetics of victims' descendants (Conner, 2020; Hines, 2018).

Another chronic problem is that Black people are more likely than other ethnicities to be misdiagnosed by GPs (Commander *et al*., 1997). Black Caribbean people are seven times more likely than white British people to be diagnosed with psychosis (The Parliamentary Office of Science and Technology, 2007). Moreover, Black people are three times more likely than white people to experience homelessness in the UK, and this is because of systemic housing discrimination, poverty and racism (Swain, 2020).

Additionally, people from racialised communities who are part of the Lesbian, Gay, Bisexual, Transgender, Queer or Questioning and Intersex (LGBTQI+) community are at a higher risk than other groups of experiencing trauma and social disadvantages. They have limited access to healthcare services through a combination of their race, ethnicity, sexual orientation, gender identity and socio-economic status (Salerno *et al*., 2020).

Refugees - another racialised community - face multiple adversities before, during and after escaping from life-threatening situations, political violence, torture and persecution. The diverse journeys such people take to escape untenable situations in their countries of origin are themselves a threat to their lives; for example, hazardous sea crossings, paying intermediaries to escape, and being criminalised, enslaved or subjected to exploitation or sexual abuse (Brodda Jansen, 2020; Krieger, 2012).

Refugees and asylum seekers often present with complex health needs and encounter hostility from host countries and public services, which see their requirements as an unwanted additional demand on the public purse. Care systems are rarely designed to cope adequately with the needs of refugees. Health practitioners are not trained to address structural and institutional racism and discrimination, a shortcoming that leads to the exclusion of the most marginalised, with little attention to social justice and fair processes as part of appropriate healthcare (Brodda Jansen, 2020; Krieger, 2012).

## TERMINOLOGY

'Trauma' is an emotional response to a wounding event, or set of events, which can be experienced in childhood and/or adulthood. 'Racial trauma' is a specific type of trauma rooted in individual and collective experiences of racism (Saleem *et al*., 2020). The historical trauma of racism - as caused for example by enslavement or forced migration - often carries forward through generations due to enduring systemic inequalities and cultural narratives that perpetuate the memory and impact of these injustices (Brave Heart *et al*., 2011; Menakem, 2017).

By 'racialised communities' we mean pluralities of people who are readily (and usually mistakenly) identified as homogeneous groups. People from racialised communities have experienced trauma from racism and faced health inequalities and barriers to accessing mental healthcare services. 'Trauma-informed care' is a framework that aims to identify and understand the impact of such traumas, create a safe environment for providers and patients, and prevent re-traumatisation.

## CURRENT PROVISIONS

Trauma-informed care, a concept which originated in the United States and is now gaining momentum in the UK, emphasises the importance of understanding, recognising and responding to the effects of all types of trauma. It aims to create supportive environments for people using health and social services to help them heal and avoid being traumatised again.

Several British models have been developed for delivering trauma-informed services in health, education and social care (Harris and Fallot, 2001; Levenson, 2017; SAMHSA, 2014). Organisations that have introduced such practices have registered significant improvements in several areas: they have made service users feel safer; they have improved respect and trust between service users and practitioners; they have empowered service users and made them feel that they can speak up and be listened to; and they have developed collaboration between practitioners and people using services (Bloom, 2013; Herman, 1992; Wilson *et al*., 2015). The needs and hopes of persons with trauma are at the centre of the services and the interventions with which they engage (Jennings, 2008; van der Kolk, 2014).

People from racialised communities are not universally supported in healthcare settings, and their experiences of some settings, such as general practice, are poor. Misdiagnosis and racial stereotyping in relation to pain control in pregnancy, for example, are common (Oparah and Bonaparte, 2015; Peckham *et al*., 2020).

Trauma-oriented therapies (Gjerstad *et al*., 2024), also known as trauma-specific therapies or trauma-focused interventions, are designed to assist individuals, particularly children and young people, in recovering from trauma. These therapies incorporate various psychological approaches to help clients process their traumatic experiences and develop healthier coping mechanisms.

These interventions provide either individual or small group support and can be effective regardless of the children's involvement with the criminal justice system.

One primary approach within trauma-specific therapies is trauma-focused cognitive behavioural therapy (TF-CBT), which seeks to modify thoughts, behaviours and emotions related to trauma, and to offer a structured framework for individuals to process their experiences. TF-CBT is particularly advantageous for children, assisting them in a secure environment to develop coping mechanisms and better understand their feelings.

Trauma-informed care goes beyond specific therapies and entails training for practitioners in broader fields, including education and policing (Gjerstad *et al*., 2024). This training enhances practitioners' comprehension of trauma, fostering an environment that is sensitive to victims' individual needs. An example is a pilot programme in the UK that paired trauma-informed practitioners with police response teams, demonstrating a successful model for embedding trauma-informed practices within law enforcement.

Among the current challenges to improving standards of trauma-informed care in racialised communities is structural racism, which is embedded in societal norms, laws, institutions and policies and creates widespread exclusions and inequalities in schools, healthcare, housing and the criminal justice system (Ahmed *et al*., 2019; Kehinde, 2019; Patel, 2016).

# METHODOLOGY

## ABOUT THE PARTNERS

The NHS RHO commissioned Centre for Mental Health and Coffee Afrik CIC to carry out a qualitative research project on trauma-informed care in racialised communities. The three organisations worked throughout in partnership with each other and with Doreen Joseph, an associate researcher with more than two decades' experience in the mental health sector.

**Centre for Mental Health (the Centre)** - an independent charity that takes the lead in challenging injustices in policies, systems and society, so that everyone can have better mental health. By building research evidence to create fairer mental health policy, it pursues equality, social justice and good mental health for all. The Centre led the literature review writing process and, along with the research associate, recruited participants and gathered and analysed quantitative and qualitative data.

**Coffee Afrik** - a community-oriented initiative in the London boroughs of Hackney, Newham and Tower Hamlets. With a team of 16 specialists in equality and mental health, it is committed to empowering marginalised communities and individuals, effecting change at grassroots level and delineating clear rehabilitation pathways. Its inclusive and open community interactions, particularly aimed at supporting diverse working-class residents, are at the heart of its approach. It has established safe spaces for social action, fostering a sense of purpose and belonging. Presently, it manages four such spaces, overseen by a committee of local residents, including those identifying as having severe mental illness, special educational needs, or as LGBTQI+. Coffee Afrik co-facilitated and hosted in-person service user focus groups, recruited participants from their community, and carried out community engagement projects.

## WHAT WE DID

Conducting a qualitative research project on the nature and effects of trauma for immigrants and people from racialised communities necessitates a deep understanding of the unique challenges and sensitivities associated with those populations. In the light of that requirement, together we sought to find ways in which mental health services can adopt a culturally competent and trauma-informed approach. This involves engaging with people from racialised communities in a collaborative and respectful way, providing culturally relevant and evidence-based interventions, and ensuring that staff are trained and supported to deliver such care. By doing so, mental health services can improve the access, quality and outcomes of care for people from racialised communities and contribute to reducing health inequalities and promoting social justice.

At the outset, we asked ourselves:

- What is the nature of trauma experienced by people from racialised communities?
- What are the root causes, and how does trauma manifest in their lives?
- How can services be improved to better support individuals from racialised communities who have endured trauma and racism, and who continue to face systemic barriers and inequalities?
- What strategies can be employed to develop resources that empower service providers to deliver effective trauma-informed care tailored to the needs of racialised communities?

In search of the answers, we resolved to:

- Explore the existing literature on trauma-informed care, the consideration of race and racism in the delivery of trauma-informed care, and experiences of systemic trauma
- Engage meaningfully with individuals with relevant lived experience to inform project design and outputs. Engagement would cover a broad range of ethnic diversity as well as consideration of asylum seekers and refugees
- Work alongside trauma-informed services - the NHS and Voluntary, Community and Social Enterprises (VCSE) - to explore the practice, impact and outcomes
- Develop resources for service providers to promote effective trauma-informed care for racialised communities.

In the preliminary stage, we embarked on an exhaustive review of the relevant literature to unravel the intricacies of trauma and trauma-informed care, drawing insights from a range of authoritative academic sources (**Appendix 1**).

We next consulted a community reference group of Black men aged 16 to 19 convened by Coffee Afrik. Our discussions were comprehensive, exploring individuals' understanding and experiences of trauma, including racial trauma, their encounters with discrimination, their satisfaction levels with the services they received, and their suggestions for service improvement. Furthermore, during the early stages of the project, Coffee Afrik, Centre for Mental Health and Doreen Joseph collectively decided on the scope and aims of the literature review. This collaboration allowed us to co-create the research questions that would guide first our online questionnaire and later online and in-person interviews and focus groups. The questions formulated showed strong awareness of the need for cultural sensitivity, specifically of the potential for misunderstanding through flawed translation and lack of awareness of possible nuances. Coffee Afrik hosted and co-facilitated two in-person focus groups in London with the Centre and Doreen Joseph which provided rich insights into trauma-informed care from the perspective of service users. Through monthly meetings, all partners checked in on the progress of the project and decided on ways to mitigate the challenges and appropriate next steps.

A questionnaire on SurveyMonkey was posted on the RHO's social media platforms over a three-month period in 2023. Its aim was to canvass the views of social and voluntary service providers. Apart from supplementary questions soliciting demographic information about the respondents, the document is as shown in **Appendix 2**.

Twenty-two service providers responded. 17 of them identified as female, four as male. One respondent chose not to answer the gender question. 23 people responded to the question on ethnicity. Eight self-identified as white; seven as Black or Black British (three of African heritage, four from the Caribbean); five as mixed (two white and Asian; one white and Black Caribbean); and three as of other mixed ethnicities. Most of them (14) worked in mental health care; three worked in the criminal justice system; and two worked in education.

Of the remaining six respondents, one worked for a charity, three for the NHS (which included a midwife and working for an ICB) and one in general practice holistic health. The age groups of the respondents were 18–24 years (4%); 25–34 (17%); 35–44 (22%); 45–54 (30%); and 55–64 (26%).

Subsequently service users were recruited using snowball sampling, via the connections of the associate researcher and Coffee Afrik. Service users were interviewed about their experiences of racialised trauma and trauma-informed care in the UK. (For a list of the questions asked, see Appendix 3.) The interviewers had previously undertaken cultural competence training that highlighted the need for them to be aware of their own preconceptions and biases, and which gave guidance on ways to deal with any distress that might be caused by triggering recollections of trauma. Some of the interviewees spoke no or insufficient English, so interpreters were used whenever required.

A total of 51 service users took part in the project. Each interview/focus group lasted between 60 and 90 minutes and took place both online and in person. 26 of the respondents were women; 22 were men; two declined to state their gender; 1 person did not answer the question. The 38 participants who revealed their ages were between 15 and 73 years old, with an average age of just under 38.

35 of those who took part were Black or Black British (29 of African heritage, 6 from the Caribbean). 7 were from Asian or Asian British communities (Indian, Chinese, Pakistani, Malaysian, Mauritian); 2 were Central American; 4 were of mixed heritage (3 white and Asian; 1 white, Caribbean and Asian); 3 participants did not notify their ethnicities. 30 of the 51 were Muslim; 13 were Christian; 2 were Sikhs; 3 had no religion; 2 preferred not to say; and 1 did not reply to the faith question.

Of the 36 participants who stated their sexual orientation, 30 identified as heterosexual, 2 as bisexual, 2 as gay, and 2 as other; 3 respondents preferred not to say, and 12 did not reply to the question. 21 of the interviewees had a disability or multiple disabilities (mobility issues, difficulties learning or concentrating, mental health, anxiety, depression, hearing and other impairments).

The interviewees lived in London, Birmingham, Bristol, Essex, Leicester, Manchester and Wolverhampton. The participants all signed consent forms. They consented to reading and understanding the participant information sheet, voluntary participation in the focus groups/interviews, provided permission for audio recordings of the focus groups, and agreed to their quotes being used in published reports. Participants were each given £25 vouchers as an expression of our gratitude for their participation.

# FINDINGS

## LITERATURE REVIEW

From the literature review (Appendix 1) we identified the actions that need to be taken by policymakers, public services and practitioners to address racial and racialised trauma. Foremost of the requirements is a combination of comprehensive policy reforms, community support programmes, trauma-informed services and coproduction (McGeown *et al*., 2024) with people with first-hand experience of such mistreatment and its lasting effects. Trauma-informed approaches are essential for creating healing environments in public-funded services across the board, but organisational challenges such as an unsupportive culture, scarcity of resources and cultural stereotypes can hinder their implementation. Comprehensive policy reforms, community support programmes and cultural competence training (Rubio, 2024) for service providers are therefore also essential for creating a more equitable environment for everyone experiencing trauma.

## QUESTIONNAIRE TO SERVICE PROVIDERS

The answers to the initial questionnaire revealed the following:

- Most respondents strongly agreed or agreed that they could identify signs of emotional distress
- Although most respondents sought support when distressed, barriers such as lack of culturally relevant services, discrimination, stigma, excessive paperwork and lack of perceived need were cited by those who did not. However, most of them recognised trauma as not only an acute event but also as a source of long-term harm
- For racial trauma, systemic and intergenerational racism emerges as a focal point, underscoring the necessity for systemic change and culturally sensitive interventions.
- Trauma-informed care descriptions reveal a clear understanding of its goals, such as minimising re-traumatisation and addressing trauma's behavioural impacts
- Over half of the respondents reported providing mental health support to individuals from racialised backgrounds
- Respondents had mixed opinions about whether their services provided trauma-informed care. Over half of the respondents strongly agreed or agreed, and a small number expressed disagreement
- A notable majority observed differences in the ways in which trauma-informed care impacted various ethnic groups, with six respondents elaborating further in additional free-text submissions. While over half of the respondents strongly agreed or agreed that their service provided trauma-informed care, the remaining half were neutral, disagreed or strongly disagreed.

## INTERVIEWS AND FOCUS GROUPS WITH SERVICE USERS

In detailed, discursive responses, interviewees and focus-group participants highlighted numerous concerns. Their often vivid and concerning accounts encompassed a wide range of privations and abuses, some of which seem rooted in deep-seated prejudice, others in the failings of a system that is either hostile to or insufficiently aware of the needs of racialised communities.

Racism in the UK was discussed as a systemic issue deeply embedded in the histories and practices of key institutions such as Parliament and the education system, as well as professions such as psychiatry. These inequities expose individuals carrying racialised trauma to further adversity. They complicate the process of articulating trauma, seeking understanding, or accessing equitable therapies, treatments and practical support. Participants described how this systemic hostility infiltrated their everyday lives, turning routine activities such as shopping or using public transport into fraught experiences often marked by aggression.

### Entrenched attitudes (interpersonal)

Also discussed was interpersonal racism, which manifests itself in direct interactions between individuals, often through overt or subtly discriminatory behaviours and language. These personal encounters can reinforce systemic inequities and significantly impact the mental health and wellbeing of people from racialised communities.

> **"I brushed a white man as I was trying to get off the bus... he swore and got angry. Another older man pushed me as I was holding my child and I fell off the bus. The police were called. It was because of my hijab."** - Somali woman

### Refugees, asylum seekers, and migrants

Refugees and asylum seekers reported profound difficulties they faced in fleeing their homes and families. Forced to leave their places of worship, culture, loved ones and community connections, many described feeling untethered and detached from their core identities. The psychological toll of leaving home, often under duress and in life-threatening situations, resulted in high levels of anxiety for adults and children alike - feelings that sometimes persisted long after the events.

The journey to safety was often fraught with challenges and setbacks, and arriving in the UK did not mark the end of these struggles. Many refugees and asylum seekers faced poor, temporary housing conditions or outright homelessness, further compounding their trauma and instability.

Participants who were migrants or refugees described significant difficulties in navigating the immigration system. Lengthy, stressful processes to apply for asylum, visas or citizenship were commonly reported, often marked by delays, rejections or the threat of deportation. Additional barriers, such as language difficulties, inadequate information and prohibitive costs, exacerbated these challenges. One participant expressed feeling stripped of dignity and rights as an asylum seeker, living in constant fear of deportation to a war-torn country. Another described feelings of isolation and depression as a migrant, exacerbated by limited access to mental health services due to their immigration status. These experiences heightened trauma and fostered a pervasive sense of insecurity and alienation.

### Intergenerational trauma

Participants highlighted the widespread but poorly understood effects of intergenerational trauma within racialised communities. Historical injustices such as the transatlantic slave trade - marked by the dehumanisation, exploitation and abuse of African peoples continue to leave deep scars.

For many, the inability to trace ancestral lineage due to incomplete or missing records underscores the ongoing legacy of displacement and erasure.

> **"It was just, you know, white people are kings and Black people's history started at slavery. So, I think from a young age that kind of has an impact."** - Research participant

## Political upheavals, colonialism and after

The psychological repercussions of political oppression, famine, wars and colonialism were also discussed. Participants from Africa, South and Central America, Europe and the Middle East described how these historical events devastated communities, forcing mass displacement.

The effects of British colonialism were cited as another source of trauma, such as the partition of India and Pakistan in 1947, which caused genocide and widespread displacement. For participants from the Caribbean, the Windrush scandal remains a potent example of systemic injustice with long-lasting cultural and political implications.

Participants described the legacies of fear and pain that persist within their diasporic and fragmented communities. When combined with contemporary racial discrimination and systemic injustice, these historical and ongoing experiences amplified negative mental health outcomes.

## Efforts to assimilate

Cultural and community resources that anchor identity and foster belonging were often disrupted for participants. Many described adapting their names, clothing and routines to fit into UK society, while downplaying abuse or discrimination faced in various settings - including schools, workplaces and public spaces - to avoid 'causing a fuss.' Others emphasised the pressure to outperform their peers in order to earn basic respect and authority. Despite their resilience and achievements, many reported never feeling fully integrated or accepted within British society.

## Early-years trauma

Several participants recounted the trauma of experiencing racism during their early school years. They noted the absence of Black history within the education system and a lack of respect for their culture, languages and religions from teachers and peers. One participant described being bullied and excluded at school, with little intervention from staff. Another was discouraged from pursuing higher education due to low teacher expectations. These experiences impacted self-esteem, motivation and achievement, limiting their opportunities and potential.

> **"So even just things like say when I was at school and when we had a teacher who was referring to their Black kids as monkeys and stuff like that, you know, it's like, yeah, so these are sort of experiences that you pick up along the way. And sometimes they can just be like covert and sometimes they can be like outright racist, but sometimes it's just so low-levels... it has a weary effect on a person."** - Research participant

## Sexual mythology

Young Somali men expressed concerns about the damaging impact of sexualised and racialised imagery on social media. These unrealistic portrayals undermined their confidence in their identity and appearance, compounding feelings of inadequacy.

## Economic hardship and housing

Economic hardship emerged as a recurring challenge for participants, with many citing the high cost of living in London as a significant barrier to safety and stability. Discussions frequently referenced the Grenfell Tower fire of 2017, highlighting the neglect of social housing residents' safety prior to the disaster and the subsequent lack of accountability from authorities. Grenfell became emblematic of the broader burdens of inequality and systemic indifference that racialised communities endure.

Secure, well-maintained housing is essential for mental health and overall wellbeing. However, participants highlighted significant barriers to accessing affordable, decent-quality housing, particularly in urban areas where many ethnic minorities reside. Overcrowded, damp, noisy and unsafe living conditions were commonly reported, all of which negatively impacted mental health and quality of life.

Discrimination and racism within housing processes were recurring issues. Participants described being denied access to social housing or private rentals because of their ethnicity, immigration status or mental health history. Additionally, experiences of harassment, abuse and violence from landlords, letting agents, neighbours and even local authorities created hostile environments. For many, these conditions led to isolation and disconnection from their support networks. Participants often felt forced to move away from their families and communities in search of housing, which exacerbated feelings of loneliness and cultural alienation in unfamiliar areas where they encountered prejudice.

## In the workplace

Participants consistently highlighted significant challenges in finding and maintaining employment.

> **"When we came to England, work was very important. We were treated as second-class citizens, so… we had to get on with low menial jobs just to get food on the table… I think we've passed that anxiety that you might get sacked if you take a day off on to the next generation."** - British Asian participant

Workplace discrimination manifested in name-calling, the use of derogatory language, and exclusion from conversations or decisions. Many reported that their concerns about these behaviours were dismissed outright, and actions to address discrimination were rare. In some cases, individuals were told to accept such behaviours as inevitable aspects of working life. This lack of acknowledgment not only perpetuated the harm but also eroded participants' sense of agency and wellbeing.

> **"At the airport I experienced a fair bit of discrimination… from the white men who worked there who looked down on me and looked down on other Indian people… The white people would get all the good jobs and all the Indian people and Black people would get the poor jobs which were more physical… At one point it got so bad I took it up with the head office… I went and spoke to them about what I was experiencing, and I felt that in the meeting… the head of human resources didn't pay really any attention to what I was saying, it was just kind of brushed off as 'It's just part of life… it's just like industrial, you know, all this name-calling, it's just part of industrial language that goes on in the workplace'. So it's like just get on with it, basically."** - Research participant

## Language barriers

Participants relied on a range of services to support their health and livelihoods, including healthcare, education, housing and law enforcement. However, they encountered both practical and psychological barriers to accessing these services. Linguistic obstacles, insufficient information and systemic biases created significant difficulties. Even after accessing services, participants reported struggling to make their voices heard or to receive basic respect, compounding their feelings of marginalisation and frustration.

## Police problems

Interactions with law enforcement often brought experiences of discrimination, violence, and criminalisation. Participants recounted incidents of being stopped, searched, harassed, or arrested without cause. Some shared their fear of contacting the police, even in situations where they were witnesses to or victims of crime, due to concerns about being blamed or mistreated. For instance, a participant whose report of domestic violence was dismissed by police and who was labelled mentally unstable.

For asylum seekers and migrants, this fear was intensified by their precarious immigration status. One participant, assaulted on the street due to his darker skin, avoided reporting the incident, fearing that engaging with the police might lead to deportation. A widespread belief among participants was that their complaints would not be taken seriously, reflecting their sense that there is a systemic dismissal of the needs and voices of racialised communities.

## Healthcare hurdles

Participants criticised mental health and social care systems for their exclusionary practices, neglect and, at times, brutality. Many described being denied the care and support they sought, with some systems actively worsening their conditions. One participant recalled their brother's tragic death following neglect by mental health services, illustrating the dire consequences of systemic failure.

Women with trauma, particularly those labelled with personality disorders, described cycles of rejection and invalidation. For asylum seekers, accessing support was even more challenging, as they often returned to precarious housing situations such as rough sleeping. Participants shared stories of clinicians failing to acknowledge the broader contexts of their circumstances, leading to a lack of empathy and care.

Accessing specialist healthcare was often complicated by unfamiliar systems and technical jargon, which created additional stress and confusion. Black women in maternity services reported inadequate pain management rooted in racist assumptions about their tolerance for pain. These prejudices led to distress and, in some cases, severe complications. For instance, a Somali woman endured 21 days of severe pain following an operation, during which medical staff dismissed her symptoms and later attempted to shift the blame onto her.

Many participants raised concerns about clinicians' lack of understanding of the link between mental and physical health. For example, one individual with PTSD and generational trauma experienced severe physical symptoms, including neurological issues and fibromyalgia. However, their GP failed to integrate mental and physical health treatments, leaving the participant without adequate care.

Deep-seated prejudices within healthcare systems were highlighted as a persistent issue. Participants described how Eurocentric medical education often excluded the specific needs of people with darker skin, leading to inadequate treatment and care.

For example, an expert by experience noted the limitations of diagnostic practices, explaining that darker skin does not show certain symptoms, such as redness or bruising, in the same way as lighter skin. These systemic oversights further marginalised participants and reflected a broader pattern of exclusion and neglect within healthcare.

Despite all these challenges, participants articulated a desire to counter negative narratives about their communities. Many sought to use their creativity and talents to reclaim their stories, challenge harmful portrayals and amplify messages of resilience and pride.

## POSSIBLE WAYS FORWARD: SOME INTERIM SUGGESTIONS

Addressing racial and racialised trauma requires tackling the root causes and ongoing impacts of racism while fostering resilience and empowerment in affected communities. Participants voiced a strong demand for proactive and sustained efforts to challenge negative narratives - harmful stereotypes and distortions perpetuated by media and dominant cultural voices, and to tackle everyday manifestations of racism, such as microaggressions, prejudice and discrimination.

Combating racism within public sector organisations, particularly in education and the criminal justice system, was identified as a critical priority. These institutions often reinforce entrenched systems of white supremacy - structures that uphold racial inequality. Participants emphasised the need to dismantle these inequities to create fairer opportunities and outcomes for racialised individuals, whose experiences are shaped by systemic discrimination.

The discussions highlighted the need to address prejudices within law enforcement, healthcare, housing and social care. Improving the quality of care provided to racialised communities was seen as essential. Participants proposed strengthening employment regulations to protect against racial discrimination and ensure accessible legal recourse. While work was recognised as a key factor in fostering mental wellbeing by providing purpose and stability, discriminatory workplaces and microaggressions were acknowledged as significant contributors to mental distress.

In the healthcare sector, participants called for training initiatives to equip professionals with the skills to counteract racism and address its psychological and emotional effects. Such courses should include guidance on how to tackle racial trauma and how to help individuals overcome imposter syndrome, a sense of self-doubt arising from systemic exclusion and marginalisation.

### Fostering community resilience

Community resilience (the collective ability to recover and adapt in the face of adversity) emerged as a recurring theme. Participants stressed the importance of fostering resilience through self-care practices, such as strategies to maintain emotional and physical health, and communal support networks that leverage shared strength and solidarity. These approaches were seen as vital for managing stressors and overcoming challenges.

Participants shared examples of economic ingenuity within their communities, including the creation of credit unions (member-owned financial cooperatives offering affordable services) and other resourceful community-driven initiatives. These efforts highlight the power of collective action and creativity in fostering resilience and opportunity.

The discussion acknowledged valuable lessons from the Māori people of New Zealand regarding trauma treatment. The Māori, indigenous Polynesians, use culturally grounded approaches to healing by integrating traditional practices, spirituality and a shared sense of identity. This perspective challenges conventional Western mental health models and underscores the benefits of incorporating diverse cultural frameworks to enhance the inclusivity and effectiveness of trauma treatment.

Participants underscored the importance of confronting racism on multiple fronts and fostering community resilience to address its impacts. Their insights highlighted key strategies, including combating negative narratives, improving care services, supporting communal self-care and economic initiatives, and integrating culturally diverse practices. These findings advocate for a holistic approach that empowers racialised communities, drives systemic change, and promotes mental health resilience in the face of racial and racialised trauma.

The narratives shared by participants underline the necessity of a multifaceted approach to confront and mitigate the effects of racism, emphasising the significance of culturally informed care, community resilience and economic ingenuity.

# CONCLUSIONS

While our research identified some common themes and patterns in the experiences of trauma among immigrants and other people from racialised communities in the UK, we acknowledge the diversity and complexity of these experiences. We recognise that trauma is not a monolithic or uniform phenomenon, but rather a dynamic and multifaceted one that is shaped by various factors, such as the individual's personal qualities, social support, cultural background and spiritual beliefs. Moreover, we understand that trauma is not influenced only by the nature, intensity and duration of the traumatic event or situation, but also by the historical, political and socio-economic context in which it occurs and in which the individual lives. Therefore, we do not wish to homogenise or oversimplify the experiences of trauma that we have heard from our participants; we wish to honour their uniqueness and specificity.

As researchers, we are keen to find a coherent and compelling account of the impact of trauma on immigrants and other people from racialised communities in the UK, but we also respect the diversity and richness of their stories, which reflect their different backgrounds, histories, experiences and identities. We are aware that the nature of the trauma they have experienced is closely related to what they, their families, and their communities have faced in their countries of origin, such as war, persecution, violence or natural disasters, as well as the challenges and difficulties they have encountered in their migration journeys and in their settlement processes in the UK.

We also recognise that the trauma people are experiencing today is situated in a specific moment in history, where globalisation, migration and multiculturalism have created new opportunities and tensions in the world, and where racism, xenophobia and other forms of discrimination have become more visible and pervasive in UK society. We are mindful that these factors can affect how they perceive, cope with, re-live, re-enact and recover from trauma, and how they construct their sense of self, belonging and agency.

One of the critical issues that our research showed is how widespread the impacts of trauma are on immigrants and other people from racialised communities in the UK. In line with the findings of our literature review, it was apparent from the interviews that trauma, as a psychological and emotional response to an event or situation that is deeply distressing or overwhelming, is a common consequence of the experiences the participants in our research have faced in the past and in the present: violence; abuse; war; persecution; natural disasters. In analysing the interviews, we learnt that trauma could have lasting adverse effects on people's mental health, wellbeing, identity and sense of belonging, especially if they do not receive adequate support and care, or if they continue to experience similarly challenging circumstances.

Our research confirms that immigrants and other people from racialised communities are more vulnerable to trauma due to their exposure to multiple and intersecting forms of oppression and discrimination, such as racism, xenophobia, sexism, classism, homophobia, islamophobia and antisemitism. These forms of oppression and discrimination create structural and systemic barriers that restrict access to education, employment, healthcare, housing and social services, and which exacerbate their victims' trauma and marginalisation.

Moreover, these forms of discrimination can also create a hostile and unwelcoming environment that undermines their dignity, safety and human rights, which can trigger or retraumatise them.

It was clear from our research that trauma-informed approaches cannot be implemented in a one-size-fits-all manner, as they need to consider the specific histories, cultures and identities of the people they serve. For immigrants and other people from racialised communities, this meant acknowledging and addressing the multiple and intersecting forms of oppression and discrimination they face, and how these affect their trauma and wellbeing. It also meant respecting and valuing their strengths, resources and diversity, and involving them in the design and delivery of the services and support they receive.

We propose the following elements for trauma-informed approaches that are culturally sensitive and responsive to the needs of immigrants and other people from racialised communities in the UK:

### A human rights perspective

Trauma-informed approaches should recognise that trauma is not only a psychological and emotional issue, but also a social and political one, which is linked to the violation of people's human rights and dignity. Therefore, trauma-informed approaches should aim to protect and promote the human rights of immigrants and other people from racialised communities, and to challenge and change the structures and systems that produce and maintain trauma and inequality.

### Cultural humility

Trauma-informed approaches should acknowledge that culture is not a static or monolithic concept, but a dynamic and complex one that influences how people understand and cope with trauma. Therefore, trauma-informed approaches should adopt a stance of cultural humility, which involves being open, curious and respectful towards the cultural backgrounds and preferences of immigrants and other people from racialised communities, and being aware of one's own assumptions, biases and limitations.

### Strengths-based approach

Trauma-informed approaches should recognise that immigrants and other people from racialised communities are not passive victims or helpless survivors, but active agents and resilient thrivers who have their own capacities, resources and coping strategies to deal with trauma. Therefore, trauma-informed approaches should focus on the strengths and assets of immigrants and other people from racialised communities and support them to use and enhance them for their healing and recovery.

### Collaborative partnership

Trauma-informed approaches should acknowledge that immigrants and other people from racialised communities are the experts of their own lives and experiences, and that they have the right to be involved in the decisions that affect them. Therefore, trauma-informed approaches should foster a collaborative partnership between immigrants and other people from racialised communities and the professionals and organisations who work with them, based on trust, respect and mutual learning.

## CHALLENGES FOR THE SECTOR

Trauma-informed approaches should understand that trauma affects not only the individual, but also the family, community and society, and that it has implications for different aspects of people's lives, such as their physical, mental, emotional, social and spiritual wellbeing. Therefore trauma-informed approaches should adopt a holistic perspective that addresses the multiple and interrelated needs and challenges of immigrants and other people from racialised communities, and which provides them with comprehensive and integrated support and services.

A challenge for developing trauma-informed responses in health, education, social and police services is the lack of awareness and understanding of the relationships between racism and trauma among practitioners. Professionals who work with immigrants and other people from racialised communities may not be aware of the multiple and cumulative forms of trauma that these populations face, such as historical, intergenerational, collective or vicarious trauma, and how they affect their mental health and wellbeing. They may also not recognise the role of racism and discrimination as sources of trauma, or the ways that racism and trauma intersect and reinforce each other. Moreover, they may not have the knowledge, skills or confidence to address the specific needs and challenges of immigrants and other people from racialised communities who may have different cultural backgrounds, languages, beliefs, values and expectations. Therefore, there is a need for more training and education on the issues of racism and trauma for practitioners across different sectors and disciplines, and for more culturally sensitive and responsive approaches to service delivery and practice.

Another challenge for developing trauma-informed responses in health, education, social and police services is the lack of clear leadership and support for this endeavour. There may not be a shared vision, commitment or strategy for implementing trauma-informed approaches at the organisational or systemic level, or for ensuring that they are consistent, coherent and coordinated across different services and sectors. There may also not be enough resources, guidance or supervision for practitioners who want to adopt trauma-informed practices, or for evaluating and monitoring the outcomes and impacts of these practices. Furthermore, there may be barriers or resistance to change within the existing structures, cultures and policies of the organisations and systems, which may not be conducive to or supportive of trauma-informed principles and values.

Therefore, there is a need for more leadership and advocacy for trauma-informed approaches, and for more collaboration and communication among different stakeholders, including immigrants and other people from racialised communities themselves, to create a shared vision and a common framework for action.

A third challenge for developing trauma-informed responses in health, education, social and police services is the potential sense of being overwhelmed that practitioners may experience when they face the magnitude and complexity of the challenge.

Practitioners who work with immigrants and other people from racialised communities may encounter high levels of stress, burnout, compassion fatigue or secondary traumatic stress as they deal with the emotional and practical demands of their work. They may also feel frustrated, helpless or hopeless as they witness the suffering and injustice that these populations endure, and the limitations of and gaps within the available services and systems. They may also feel isolated, unsupported or unappreciated as they struggle to make a difference in a challenging and often hostile environment.

There is thus also a need for more self-care and peer support for practitioners who work with trauma-affected populations, and for more recognition and appreciation of their efforts and contributions. There is also a need for more hope and optimism, and for celebrating the small successes and the positive changes that can be achieved through trauma-informed approaches.

## IMPLICATIONS

This research has profound implications for the mental health services themselves and wider public policy. The UK Government and the public services it funds need to assertively identify and address the causes and consequences of racism and its impacts on the mental health and wellbeing of people from racialised communities. This requires a systemic and structural approach that challenges the policies, practices and norms that perpetuate racial discrimination and inequality in public services, civic life and laws.

This would also entail holding institutions and individuals accountable for their actions and inactions, and providing reparations and justice for those who have been harmed by racism.

It is clear that we need a systematic, system-wide roll-out of trauma-informed and culturally sensitive services in the NHS and other public services. This would involve adopting a holistic approach that recognises the impact of trauma on physical, psychological and social wellbeing, and addresses the root causes of trauma, such as racism, poverty and violence.

At every level of the health and care system, statutory commissioners and charitable funders should prioritise funding mental health organisations, including those from the VCSE sector which specifically cater to racialised communities, ensuring that therapy is culturally relevant and accessible, and supporting research on trauma-informed care in these communities. This would enable the development and evaluation of evidence-based interventions that meet the needs and preferences of service users from diverse backgrounds and address the gaps in knowledge and data on trauma and mental health in racialised communities.

The NHS itself should seek to increase awareness of mental health in racialised communities by making mental health awareness campaigns accessible through social media and printed media and improving the marketing and promotion of mental health services within community settings. This would help to reduce the stigma and discrimination associated with mental health problems, increase the uptake of services, and empower service users to seek help and support when needed.

The implications of this report extend into everyday practice in mental health services and beyond. We need to train professionals in trauma-informed care, overcome language barriers by providing interpreters who speak community languages, and promote a focus on intersectionality to consider the unique needs of neurodiverse, LGBTQI+, and 'looked after children' within mental health services. This would enhance the skills and competencies of professionals to provide respectful, empathetic and non-judgmental care, and foster a culture of trust and collaboration between providers and service users.

Professionals should provide safe spaces for service users from racialised communities by actively listening to their needs and experiences, and not dismiss their pain and trauma, especially those of Black women. This would validate the lived realities people bring to their contact with mental health services, acknowledge the historical and structural factors that contribute to their trauma, and create a sense of belonging and safety within the service.

But mental health services cannot address the depth of this alone. Experiences of racial trauma precede people's contact with mental health services, and it is essential to take action to prevent the harms that it causes. For example, we need schools and colleges to educate children on racism, including lessons on the history of the UK that cover topics such as colonialism, Windrush and slavery, and for teachers to be trained to understand and address racial micro-aggressions so that they can protect children in racialised communities from bullying and discrimination. This would foster a positive sense of identity and self-esteem among children from racialised communities and promote a culture of respect and inclusion among all students.

## LIMITATIONS OF THE STUDY

We acknowledge the limitations of our study, which are related to the scope, method and sample of our research. We recognise that our study focused only on the psychological and emotional impact of trauma on immigrants and other people from racialised communities in the UK. We did not explore other dimensions, such as the physical, social or spiritual ones, which might also be relevant and important for this population. We acknowledge that our study adopted a qualitative and interpretive approach that did not provide quantitative or objective measures of the prevalence, severity or outcomes of trauma.

We also recognise that our analysis was influenced by our own perspectives and assumptions, and that other researchers might have different interpretations of the data. We acknowledge that our study involved a small and non-representative sample of immigrants and other people from racialised communities in the UK who were recruited through convenience and snowball sampling methods. We do not claim that our findings are generalisable or representative of the whole population, but rather that they reflect the views and experiences of a specific group of participants who might have different characteristics, backgrounds and needs from other immigrants and other people from racialised communities in the UK.

We suggest that future research on the experiences of trauma among immigrants and other people from racialised communities in the UK should address these limitations and explore other aspects, methods and samples of this topic. It should:

- Examine the physical, social and spiritual dimensions of trauma, and how they interact with the psychological and emotional ones
- Use mixed methods or triangulation approaches, which combine qualitative and quantitative data to provide a more comprehensive and robust picture of the impact of trauma on this population
- Involve larger and more diverse samples of immigrants and other people from racialised communities in the UK, who could be recruited through more systematic and representative sampling methods, to increase the generalisability and validity of the findings.

# RECOMMENDATIONS

1. NHS England/DHSC must continue to implement, in full, the Patient and Carer Race Equality Framework (PCREF) across all mental health services for all ages, with clear accountability structures for the completion of this important transformation programme. This should include board-level accountability and clear public milestones for providers.
2. The Government must take assertive and concerted action to tackle racism and racial inequality. The Government's pledge to create a new Race Equality Act is an important start, but it requires cross-government action to address all dimensions of injustice and inequity. The eventual Act should have enforceable duties, mandatory impact assessments, and measurable outcome targets across health, education, housing and justice.
3. Every integrated care board (ICB) must ensure that it is commissioning mental health support which effectively meets the needs of racialised and marginalised communities. This should be done in line with the Strategic Commissioning Framework but must include using data about need and service provision to identify gaps or quality concerns in existing provision. Plans should be codesigned and coproduced with people and organisations from racialised communities.
4. All NHS-funded mental health service providers must embed trauma-informed and anti-racist practice as core organisational standards across all their services, with a deep awareness of intersections with gender, sexuality, neurodiversity and other dimensions of inequality and inequity. This should include mandatory training, outine monitoring of disparities in access and outcomes, and transparent reporting on progress, with accountability at executive and Board level.
5. The Care Quality Commission must explicitly assess implementation of PCREF and trauma-informed practice within inspection frameworks, publish ratings on equity performance, and require time-bound improvement plans where standards are not met.
6. NHS, local authority, charitable and research funders should provide secure and sustainable funding for community-led organisations, both as providers of support and as advocates for their communities. They should adapt commissioning and grant criteria to recognise community-based evidence, reduce administrative barriers, and promote equitable access to funding.
7. Training providers and professional bodies across all mental health professions must make trauma-informed and anti-racist practice mandatory within pre-registration training and CPD requirements, with assessed competencies and revalidation standards aligned to these principles.
8. The Department for Education should require all schools and colleges to include education about racism and colonialism and require teacher training to include learning about racism and microaggressions in school and college settings.

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# APPENDIX ONE: LITERATURE REVIEW

## TRAUMA AND RACIAL TRAUMA

According to the American Psychological Society, trauma is defined as an emotional response to a terrible event. Trauma can also be defined as an experience that creates a sense of helplessness and fear which overwhelms a person's resources for coping (Hopper er al., 2010).

Adverse Childhood Experiences (ACEs) refer to a wide range of traumatic or stressful experiences that children and young people are exposed to while growing up (NHS Highland, 2018). In the UK, about half of the population have at least one ACE. ACEs could be from experiences of racism, poverty, verbal abuse, physical abuse, neglect, sexual abuse, and death of a loved one. Research has found that people who have acquired trauma from ACEs are more likely to have mental health issues in adulthood and use healthcare services more frequently compared to their counterparts who do not have ACEs. Research has also found that people from racialised communities and low socio-economic backgrounds are more likely to experience trauma compared to their counterparts (Sweeney *et al*., 2016; Emsley *et al*., 2022; Dawson *et al*., 2021; Hatch and Dohrenwend, 2007; Joseph *et al*., 2020).

In some cases, the use of mental health services by these individuals who have experienced trauma can cause re-traumatisation - getting traumatised again. Re-traumatisation in mental healthcare settings occurs when an individual is triggered by certain procedures or actions such as restraint, round the clock observation, body searches, seclusion, forced medication, and coercive practices by healthcare professionals (Sweeney *et al*., 2018).

It is also possible that healthcare staff have also faced trauma in their personal lives or while working at healthcare facilities and this can negatively impact their behaviour toward patients. The negative impact of trauma on people further reinforces the need for trauma-informed approaches in healthcare settings (Dawson *et al*., 2021; Sweeney *et al*., 2018).

Racial trauma involves the experience of danger related to both past and ongoing prejudicial treatment, including physical violence, threat of harm, shaming interactions, and ongoing vicarious trauma due to witnessing harm to other Black, Indigenous, and people of colour (BIPOC). Complex trauma is an integrative term that encompasses both the exposure to multiple, chronic traumatic experiences as well as the wide-ranging and long-term impact of these experiences. As such, racial trauma can be conceptualised as a specific form of complex trauma (Complex trauma, 2023).

Racial trauma can be caused by experiencing racism and racial discrimination and be cumulative. Hankerson (2022) suggests that cumulative psychological consequences result from traumatic experiences and cites studies which indicate that depression may be transmitted down intergenerationally, including through pregnancy of severely depressed mothers. The same author suggests that depression risk among those directly affected by structural racism and cumulative trauma may extend to their descendants.

## TRAUMA-INFORMED CARE AND TRAUMA-INFORMED APPROACHES

Trauma-informed approaches originated in the USA which is where majority of trauma-informed studies have been carried out (Sweeney *et al*., 2016; Elmsley *et al*., 2022; Dawson *et al*., 2021).

In the UK, trauma-informed care has been recently introduced into the NHS Long-term plan and the NHS Mental Health Implementation Plan in the UK (National Health Service, 2019). Some NHS Trusts are carrying out training courses on trauma for professionals who attend to people that have experienced trauma. For example, The Travis & Portman NHS Foundation Trust offers a training course for professionals to increase their understanding of the principles and practice of a psychoanalytic approach to trauma and therapy. The course also aims to gain understanding of the impact of traumatic events on the mind and develop a greater awareness of the contribution psychoanalytic ideas can make to therapeutic work with traumatised individuals and groups.

According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) (2014) report on trauma-informed approaches, a trauma-informed organisation or system realises the impact of trauma on people and their families. The organisation should also be able to recognise the signs and symptoms of trauma and respond by integrating knowledge about trauma into policies to further prevent re-traumatisation. Furthermore, SAMHSA proposed six key principles of trauma-informed care:

- Safety
- Trustworthiness and transparency
- Peer support
- Collaboration and mutuality
- Empowerment, voice, and choice
- Cultural, historical, and gender approaches.

Similarly, a study by Bath (2008) suggested three pillars of trauma-informed care for children:

- Safety
- Connections
- Managing emotions.

SAMHSA also proposed ten implementation domains for trauma-informed care:

- Governance and leadership
- Policy
- Physical environment
- Engagement and involvement
- Cross-sector collaboration
- Screening, assessment, treatment services
- Training and workforce development
- Progress monitoring and quality assurance
- Financing
- Evaluation.

These principles and implementation domains aim to inform trauma-informed care in organisations. The importance of organisations and communities in tackling trauma was also highlighted.

Hopper *et al*., (2010) defined trauma-informed care as a 'strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasises physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.'

Their research explored trauma-informed care in homelessness service settings, and it was found that trauma awareness, choice and empowerment, safety, and focus on strength were important principles for implementing trauma-informed care.

There were barriers to the implementation of trauma-informed care such as resistance from service providers because of lack of confidence in addressing traumas, time-consuming process, and difficulty changing an already established system. These authors also proposed that the implementation of trauma-informed care would be made effective by training staff and raising awareness on traumas, providing support and supervision to staff undergoing training, assessing the progress of the training, including cultural sensitivity, and evaluating the effectiveness of trauma-informed services by including people who have suffered from trauma and getting feedback from them. These trauma-informed recommendations are said to improve behavioural outcomes and housing stability for homeless people (Hopper *et al*., 2010).

An earlier study by Elliott *et al*., (2005), explored trauma-informed services for women. Women who experience trauma are usually overlooked, therefore, the authors proposed ten principles of trauma-informed services that would be beneficial to them. These are:

- Principle 1: Trauma-informed services recognise the impact of violence and victimisation on development and coping strategies
- Principle 2: Trauma-Informed services identify recovery from trauma as a primary goal
- Principle 3: Trauma-informed services employ an empowerment model
- Principle 4: Trauma-informed services strive to maximise a woman's choices and control over her recovery
- Principle 5: Trauma-informed services are based in a relational collaboration.
- Principle 6: Trauma-informed services create an atmosphere that is respectful of survivors' need for safety, respect, and acceptance
- Principle 7: Trauma-informed services emphasise women's strengths, highlighting adaptations over symptoms and resilience over pathology
- Principle 8: The goal of trauma-informed services is to minimise the possibilities of re-traumatisation
- Principle 9: Trauma-informed services strive to be culturally competent and to understand each woman in the context of her life experiences and cultural background
- Principle 10: Trauma-informed agencies solicit consumer input and involve consumers in designing and evaluating services.

SAMSHA (2014), Hopper *et al*. (2010), and Elliot *et al*. (2005) all share similar ideas and principles of trauma-informed care. They highlight the benefits of trauma-informed care and the importance of using the perspectives of those affected by trauma to inform policies and interventions.

More recently, Emsley *et al*. (2022) carried out a qualitative study of health policies and professional perspectives in the UK. The healthcare professionals that were interviewed expressed that trauma-informed care in the UK was not centralised. It was also suggested that having a more standardised policy for trauma-informed care as well as funding by the government will be beneficial. Understanding the perspectives of professionals may also be beneficial for creating effective trauma-informed care policies.

## MENTAL HEALTH INEQUALITIES AND TRAUMA IN RACIALISED COMMUNITIES

The NHS Race & Health Observatory (RHO) (2022) carried out research on ethnic inequalities in mental health services. It showed that people from racialised communities are less likely to receive adequate support from mental health services. People from racialised communities also have negative experiences with mental healthcare professionals, and in some cases, do not have access mental healthcare services at all. It has also been found that people from racialised communities do not trust General Practitioners (GPs) or mental healthcare professionals which makes them hesitant to seek mental health support.

In the same vein, a qualitative study by Memon *et al*. (2016), found that fear of discrimination from mental healthcare professionals, stigma, racism, and communication barriers are factors that discourage people from racialised communities from seeking support from mental healthcare services (Memon *et al*., 2016). Culture also plays a key role in trauma responses. Research has found that there is an increased risk of PTSD in a wide range of cultures often because of experiencing traumatic events such as genocide or natural disasters (SAMHSA, 2014).

People from racialised communities specifically the Black community have experienced historical trauma because of racism, slavery, and segregation (Conner, 2020). African-Caribbean people from the Windrush generation also faced trauma and discrimination when they arrived in Britain in the late 1940s. The people from the Windrush generation and their descendants are still facing trauma and emotional distress today.

The Windrush scandal (the unjust detention, denial of legal rights and deportation of immigrants from the West Indies) is further proof of this (Hines, 2018; Joint Council for The Welfare of Immigrants, 2020). Historical trauma has increased the risk of mental health disorders such as PTSD, anxiety, and depression in the Black community. Research has also found that historical trauma can be passed down to future generations and in some cases, has a negative effect on the genetics of descendants (Conner, 2020; Hines, 2018).

Commander *et al*. (1997) found that Black people are more likely to be misdiagnosed at the GP compared to other ethnicities. Black Caribbean people have also been found to have seven times higher rates of psychosis diagnosis than white British people (The Parliamentary Office of Science and Technology, 2007). Black people are also three times more likely to experience homelessness in the UK and this is because of systemic housing discrimination, poverty, and racism (Swain, 2020).

Additionally, people from racialised communities who are part of the Lesbian, Gay, Bisexual, Transgender, Queer or Questioning and Intersex (LGBTQI+) community are at a higher risk of experiencing trauma and social disadvantages. They also face barriers such as limited access to healthcare services because of the combination of their race, ethnicity, sexual orientation, gender identity, and socio-economic status (Salerno *et al*., 2020).

## IMMIGRATION, MIGRATION, AND RESETTLEMENT CONSIDERATIONS

Refugees face multiple adversities before, during and after escaping from life-threatening situations, political violence, torture and persecution. They present with complex health needs and encounter hostility from host countries and public services, which see their needs as an additional demand on the public purse. Care systems are rarely designed to fully address the needs of refugees. Health practitioners are not trained to address structural and institutional racism and discrimination, which leads to exclusion of the most marginalised, with little attention to social justice and fair processes as part of appropriate healthcare (Brodda Jansen, 2020; Krieger, 2012).

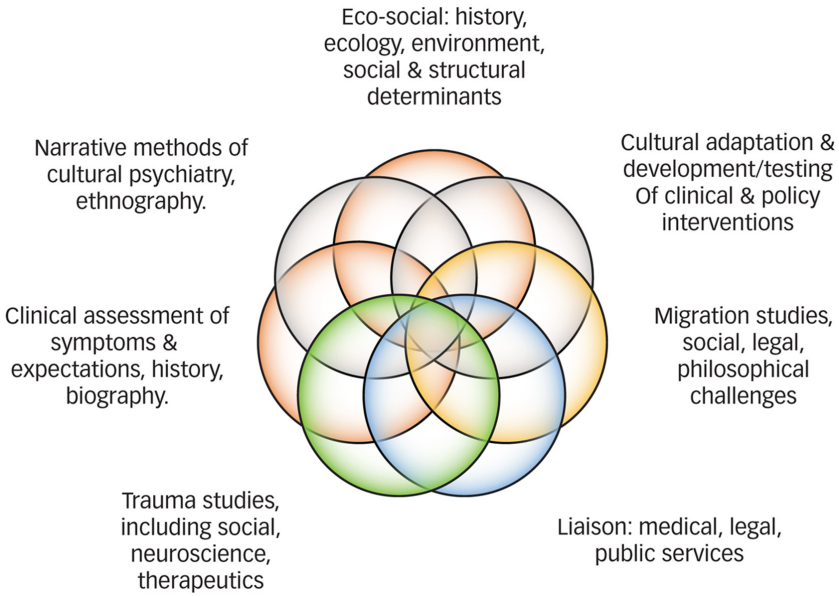
The diverse journeys people take to escape untenable situations in their countries of origin are themselves a threat to their lives; for example, hazardous sea crossings, paying intermediaries to escape and being criminalised, enslaved or subject to exploitation or sexual abuse (Brodda Jansen, 2020; Krieger, 2012). There are marked variations in the post-migration experience in asylum countries, including social isolation, stigma, discrimination, gender violence, racism, criminalisation, unemployment, and poverty (Bhui, 2022).

The Cultural Formulation Interview in the DSM-5 (guide used by mental health professionals to define and diagnose mental disorders) emphasises the use of narrative methods to ensure the patient's specific story is embraced, heard, noted and built upon in this way:

"... basic interviewing skills extend to the art of conducting a person-centred, culturally informed evaluation ... flexible responses to the specifics of the person, problem, setting, and other elements of the interview ... shaped by the identity and social position of both patient and clinician." Lewis-Fernándes *et al*., 2020)

Refugees experience multiple social, political, ethical, legal and philosophical dilemmas when experiencing distress, and when they must make decisions about who can help them with the totality of their world view ...' The Refugee Rose (figure 1) shows the complex influences and bodies of scholarship that need to be aligned for effective assessment, with implications for clinical training, continuing professional development and self-care (Bhui, 2022).

**Figure 1: Refugee rose of competencies and capabilities for mental healthcare (Bhui, 2022)**



## TRAUMA-INFORMED CARE AND RACIALISED COMMUNITIES

These traumas, inequalities, and barriers reinforce the need for trauma-informed care for racialised communities. In the USA, the Centre for Healthcare Strategies recommended six steps to be taken when incorporating racial equity into trauma-informed care. This includes involving higher-ups/the top strategic level from the start of the implementation of trauma-informed approaches; building knowledge on racism by everyone in the organisation from top to bottom; specifically defining what racial equity means in the organisation; establishing accountability metrics, elevating patient and community voices to disrupt existing power structures, and supporting staff from racialised communities and their experiences (Centre for Healthcare Strategies, 2021).

In the same vein, Powell *et al*. (2022) on behalf of National Child Traumatic Stress Network (NCTSN) explored the principles of an anti-racist trauma-informed organisation. They emphasise the need for understanding trauma in racialised communities, specifically Black people: "Understanding a family and their context requires an intentional and deep understanding of historical trauma, intergenerational trauma, structural racism, and power. Similarly, meaningful partnerships with families require an intentional and deep understanding of how systems induce trauma, perpetuate institutional and interpersonal racism, and inequitably distribute power. Neither familial nor structural understanding of these processes can be achieved without also addressing how they intersect with culture, history, race, gender identity, location, social hierarchies, and power." (Powell *et al*., 2022).

This study also explored the importance of radical healing frameworks that incorporate trauma-informed lenses and the importance of not only thoughts of anti-racism but acting and implementing anti-racist trauma-informed principles. These principles are listed below.

### Bearing witness, centering voices, & honouring lived experience:

- We proactively centre, amplify, and learn from the voices of those most impacted by racism and trauma, bearing compassionate and non-judgmental witness to their stories and realities
- We honour everyone's intrinsic value, lived experience, humanity, and innate strengths, including the various unique social identities they embody (e.g. race, gender identity, ethnicity, sexual orientation) and the strengths and protective factors of their communities

### Organisational values, governance, & strategic oversight:

- We commit to equity-based governance, power redistribution, and shared decision-making processes across all staffing levels and with the communities we serve
- We acknowledge the impact of racism, historical trauma, power dynamics, and systemic inequities
- We commit to taking sustained steps to dismantle racism, white supremacy, and privilege in our structures, policies, procedures, practices, performance evaluations, and outcomes
- We promote accountability and transparency in decision-making and leadership with all those who are impacted, including partners and those accessing services.

### Structural reforms, partnerships and systems change:

- We commit to socio-structural reforms and promote practices designed to foster truth, atonement, and collective repair and to enhance radical healing of people who are Black
- We commit to addressing conflicts when partners and funding sources actively cause harm to Black communities and/or limit anti-racist work

- We acknowledge the ways in which systems have been used to control and destroy Black bodies and harm Black families, and that understanding informs how we engage with and confront those systems.

### Human resources, staff support & leadership development:

- We prioritise the hiring, development, promotion, and retention of people who are Black at all levels of the organisation
- We value, support, and cultivate leaders and managers who continually examine, acknowledge, and address the ways in which they and their organisations may contribute to oppression
- We support holistic wellbeing for Black staff
- We assume responsibility for providing staff with the necessary knowledge and skills required to support staff and deliver care to Black communities
- We seek, implement, and invest in interventions and innovations designed by Black practitioners and in close collaboration with Black communities.

These principles were explored in detail in this report and four steps were proposed for putting the principles into sustained action. These are: assess, endorse, enable and enact. They also highlighted the need for carrying out assessments of progress and challenges (Powell, 2022).

Looking at the education sector, Joseph *et al*. (2020) carried out a research study on trauma-informed care in Black and Brown students. They explored the importance of staff and teachers understanding the traumas that are specific to children from racialised communities. Students from racialised communities have been found to experience racism and are at a higher risk of receiving disciplinary actions.

The authors propose a trauma-informed framework for students of colour that involves integrating critical race theory (CRT), restorative practices, interprofessional practice, and other principles of trauma-informed care from the SAMHSA guidance on trauma-informed care. Some of these principles include safety, concern, culture, history, and identity (Joseph *et al*., 2020). The effectiveness of trauma-informed care was explored in elementary schools in Washington, USA. The teachers were made aware of ACEs, trauma, and attachment styles during training workshops hosted by the Washington State University Area Health Education Center (AHEC). This training increased awareness of complex traumas and ACEs as well as how to handle them. After the training and implementation of trauma-informed practices by the schools, the children were found to be calmer and happier with one school having a 30% drop in suspensions (Stevens, 2013). The race of the children in the elementary school was not mentioned, therefore, the effectiveness of this intervention on children from racialised communities is not known. However, it can be inferred that combining the components of this intervention with Joseph *et al*. (2020)'s principles of trauma-informed care for children from racialised groups could be used to inform an intervention that could be effective for children from racialised communities.

Willey *et al*. (2021) explored racism and trauma-informed care for people seeking asylum in Australia. It has been found that people seeking asylum have poorer health outcomes and receive poorer quality healthcare due to discrimination and racism in the healthcare system. Most people seeking asylum have already experienced some form of trauma and this is made worse by the negative treatment they receive in the countries they are seeking asylum. The trauma experienced in their home countries and the trauma experienced in the new countries can lead to PTSD, anxiety disorders, and depressive disorders as well as other long-term physical issues.

It is also sometimes difficult for asylum seekers to discuss their trauma with healthcare

professionals, and in some cases, cause re-traumatisation which is more likely to happen when healthcare professionals do not possess an understanding of how to handle people who have experienced trauma. To tackle this, Willey *et al*. (2021) recommended that healthcare professionals should be trauma-informed and sensitive to the trauma and experiences of people seeking asylum. This includes identifying and recognising symptoms of trauma, implementing connection and safety, and giving the patient a sense of agency, control, and choice.

For the implementation of trauma-informed care in racialised communities, organisations such as the NHS Race & Health Observatory (RHO) and Coffee Afrik have been exploring projects relating to mental health and trauma-informed care in racialised communities in the UK. In one project, Coffee Afrik carried out a peer-to-peer support programme for older Somali women experiencing mental health issues. It was found that 49% of Somali refugees meet the criteria for post-traumatic stress and that the Somali community in London also have additional barriers to accessing care. These barriers include a lack of trust in the system and fear, anxiety over immigration status and access to housing, and cultural barriers.

The Covid-19 pandemic had a negative impact on the Somali population. Coffee Afrik's digital peer to peer women's support group proved to be beneficial to the Somali community in East London by improving their mood, morale, and resilience (Coffee Afrik, 2021). Coffee Afrik (2021) also highlighted the effectiveness of using their culturally sensitive referral pathway model in their projects:

> **"Moreover, the incorporation of our culturally sensitive referral pathway model has eased the process in which clients are referred to healthcare professionals and providers."**
> Coffee Afrik

As mentioned in other research papers, cultural sensitivity and competence are important for implementing effective trauma-informed care for people from racialised communities which is evidenced by Coffee Afrik's (2021) project:

> **"Understanding the importance of cultural competence in providing care to clients from diverse backgrounds cannot be overlooked, with the success of this project testament to this. As such we shall continually promote the need for culturally sensitive services embedded within healthcare services, in the hopes of reducing health disparities."**
> Coffee Afrik

Similarly, a review by Curtis *et al*, (2019) explored cultural safety and cultural competency. Although the review was based on data from New Zealand, the findings could be considered regarding the UK healthcare system. It was said that the wide range of definitions of cultural competency as well as variations in policy across different health sectors has reduced the potential for a common, shared understanding of what cultural competency represents and what interventions are needed.

Health organisations have mostly placed cultural competency in an individualised way rather than rooting it in organisational/systemic processes. Therefore, it was argued that cultural safety could be more useful than cultural competency to achieve health equity. This involved exploring the definitions of cultural competence vs cultural safety as well as healthcare organisations and health systems engaging in working towards cultural safety and critical consciousness. To do this, Curtis *et al*. (2019) emphasised the need for healthcare organisations to critique the 'taken for granted' power structures and to challenge their own culture and cultural systems rather than just prioritise becoming 'competent' in the cultures of others.

According to Curtis *et al*:

"Cultural safety requires healthcare professionals and their associated healthcare organisations to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery. This requires individual healthcare professionals and healthcare organisations to acknowledge and address their own biases, attitudes, assumptions, stereotypes, prejudices, structures, and characteristics that may affect the quality of care provided. In doing so, cultural safety encompasses a critical consciousness where healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities, and as measured through progress towards achieving health equity. Cultural safety requires healthcare professionals and their associated healthcare organisations to influence healthcare to reduce bias and achieve equity within the workforce and working environment."

The same authors' approach to cultural safety adopts the following core principles:

- Be clearly focused on achieving health equity, with measurable progress towards this endpoint
- Be centred on clarified concepts of cultural safety and critical consciousness rather than narrow based notions of cultural competency
- Be focused on the application of cultural safety within a healthcare systemic/organisational context in addition to the individual health provider-patient interface
- Focus on cultural safety activities that extend beyond acquiring knowledge about 'other cultures' and developing appropriate skills and attitudes and move to interventions that acknowledge and address biases and stereotypes
- Promote the framing of cultural safety as requiring a focus on power relationships and inequities within health care interactions that reflect historical and social dynamics
- Not be limited to formal training curricula but be aligned across all training/practice environments, systems, structures, and policies.

Curtis *et al*.'s regulators to taking a more comprehensive approach to cultural safety are as follows:

- Mandate evidence of engagement and transformation in cultural safety activities as a part of vocational training and professional development
- Include evidence of cultural safety (of organisations and practitioners) as a requirement for accreditation and ongoing certification
- Ensure that cultural safety is assessed by the systematic monitoring and assessment of inequities (in health workforce and health outcomes)
- Require cultural safety training and performance monitoring for staff, supervisors, and assessors
- Acknowledge that cultural safety is an independent requirement that relates to, but is not restricted to, expectations for competency in ethnic or indigenous health.

Furthermore, a study by Lokugamage *et al*. (2023) explored how cultural safety can be translated to the UK. They highlighted the importance of acknowledging the Indigenous origins of the New Zealand study. A 'cultural safety' tree was developed by the authors below as a guide to show how cultural safety can be translated to the UK.

Link: **Infographic of the cultural safety tree**, Lokugamage et al. (2023)

## CONCLUSION AND IMPLICATIONS FOR OUR RESEARCH

There are various reports, articles, and journals on trauma and trauma-informed care specifically on the concepts, principles, implementation, and recommendations for trauma-informed care.

However, few studies explore the effectiveness, evaluation results, and the long-term effects of trauma-informed care on the wellbeing and mental health of people who used the service. A systematic review by Champine *et al*. (2019) also explored the various trauma-informed approaches in different systems and found that most studies did not include details of their measures.

A major finding from this literature review is that the UK has plans to implement trauma-informed care, and that some organisations have used trauma-informed approaches, but it has not yet been centralised or widely used. However, guidance on the definition of trauma-informed practice has been published by the UK Government (Office for Health Improvement and Disparities, 2022).

Furthermore, drawing from other reviews by McCarthy *et al*. (2020) and Lewis *et al*. (2022), healthcare organisations have implemented trauma-informed approaches in different ways.

This includes allocated budget, staff training and support, identification of patients affected by trauma, improvement of environment, cross-sector collaboration, engagement of people with lived experience (coproduction), support from management, written policies and procedures, and ongoing evaluation.

Research has also found evidence that integrating several components of trauma-informed care could create a safe healthcare environment for patients and staff and improve patients' health and satisfaction. Some studies have also suggested that cultural sensitivity and the inclusion of perspectives of those who have lived experience, and coproduction with people who have lived experience of trauma is useful for informing trauma-informed care.

Bloom (2016) also highlighted the importance of not only educating professionals but also educating everyone connected to mental health organisations - consultants, staff, board members and other service providers. It was also suggested that a trauma-informed environment should involve designing innovative practices and policies as well as providing individuals who have experienced trauma with useful skills to identify and positively handle the impacts of their trauma. Additionally, Bloom (2016) suggested that trauma-informed institutions should 'perform basic screening and assessment to discover which individuals or families might benefit from or desperately need further treatment.'

The barriers to implementing trauma-informed care were discussed in several research journals as well as possible recommendations for tackling these issues. The production of an evidence-informed guidance by the Government is needed and the cost-effectiveness of trauma-informed approaches should be considered.

Trauma-informed care should be tailored to the needs of people that need it, such as people from racialised communities who constantly face health inequalities, racism, and trauma. An awareness of intersectionality is also important. Factors such as age, race, gender, and sexual orientation as well as the unique experiences of people from multiple marginalised groups should be considered when informing trauma-informed practices for people from racialised communities. Incorporating cultural safety practices should also be considered.

Only a few studies in literature explored trauma-informed care for racialised communities comprehensively and this is where the need for our research comes in. The involvement of people from racialised communities with lived experiences could be very beneficial for informing effective practices, recommending effective policies, improving services, patient experience, and improving the health of people from racialised communities.

# APPENDIX TWO:
# ONLINE QUESTIONNAIRE FOR PROFESSIONALS

Apart from supplementary questions soliciting demographic information about the respondents, the questionnaire was as reproduced below:

1. **How would you rate your understanding of:**

Trauma

Racial trauma

Trauma-informed care

Far above average/Above average/Average/Below average/Far below average

2. **Can you explain your understanding of:**

Trauma

Racial trauma

Trauma-informed care

3. **I will be able to recognise when someone is displaying signs of emotional distress.**

Strongly agree/Agree/Neither agree nor disagree/Disagree/Strongly disagree

4. **I have a good understanding of what mental health is.**

Strongly agree/Agree/Neither agree nor disagree/Disagree/Strongly disagree

5. **How will you rate your mental health currently?**

Excellent/Very Good/Good/Fair/Poor

6. **Have you sought mental health support when you were distressed?**

Yes/No/Prefer not to say

7. **If not, why didn't you?**

The service was not culturally relevant/I felt discriminated against/Too much paperwork/Long waiting times/Stigma from colleagues/Cost/Other (please specify)

8. **Have you provided mental health support to someone from a racialised background?**

Yes/No

9. **The service I am a part of provides trauma-informed care.**

Strongly agree/Agree/Neither agree nor disagree/Disagree/Strongly disagree

10. **Have you noticed a difference in the impact of your trauma-informed service on different ethnicities?**

Yes/No

11. **If yes:**

What has been the impact of your trauma-informed care service on people from racialised communities?

What has been the difference in impact for specific racialised communities, or subsections within these communities?

What are the outcomes of your services? Do they differ for people from racialised communities? How?

12. **My service has plans to be more trauma-informed.**

Strongly agree/Agree/Neither agree nor disagree/Disagree/Strongly disagree

13. **My service has plans to be more culturally appropriate.**

Strongly agree/Agree/Neither agree nor disagree/Disagree/Strongly disagree

14. **In what ways does your service plan to be more:**

Trauma-informed

Culturally appropriate

15. **As a professional, I prefer face to face engagement to online engagement.**

Strongly agree/Agree/Neither agree nor disagree/Disagree/Strongly disagree

16. **As a professional, the service I am a part of recognises the ethnicity/culture and the multiple disadvantages experienced by our service users.**

Strongly agree/Agree/Neither agree nor disagree/Disagree/Strongly disagree

17. **How does the service do this?**

18. **Why does the service not do this?**

19. **I think services should be more racially trauma-informed in their delivery.**

Strongly agree/Agree/Neither agree nor disagree/Disagree/Strongly disagree

20. **What kind of resources would help to implement trauma-informed care for racialised communities?**

21. **What do you think needs to change? How can these changes happen right now?**

# APPENDIX THREE:
# SERVICE USER INTERVIEW/FOCUS GROUP QUESTIONS

1. When in your life have you encountered public/voluntary services? (Social services, education, employment, mental health, criminal justice system.)
2. What do you understand about (1) Trauma (2) Racial trauma?
3. How would you describe someone who is experiencing emotional distress?
4. What is your understanding of mental health?
5. How will you rate your mental health on a scale of 1-10? (1 is poor and 10 is very good.)
6. Have you sought mental health support? If so, what was it and were you satisfied with it?
7. If you haven't sought mental health support when you were distressed, why didn't you? What did you do instead?
8. What has been the difference in quality of services between face-to-face and online?
9. Would you say that these services recognised your ethnicity/culture and the multiple disadvantages that may come with it as a factor in the type of trauma you have experienced?
10. Have you ever experienced discrimination?

    Because of your race or religion/faith?
11. Have you experienced discrimination in regard to education, housing, employment, health services or social services? Can you tell us more?
12. What would make services more trauma-informed in their delivery? i.e., more sensitive to people who have experienced trauma?
13. How would you personally benefit from a culturally appropriate trauma-informed service? Could this be applicable to the rest of the community?
14. What do you think needs to change? How can these changes happen right now?
15. Is there anything else you would like to tell us that is relevant?

CENTRE FOR MENTAL HEALTH

# TRAUMA-INFORMED CARE AND RACIALISED COMMUNITIES

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Image: istockphoto.com/portfolio/AmberNFord

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